Ko'olau Audiology & Hearing Aid Services LLC
808 263-4111
Fax: 808 263-4114
40 Aulike St., Ste 211 - Kailua, HI 96734

Acknowledgement of Receipt of Notice

I hereby acknowledge that I have read this medical practices notice of Privacy Practices.

Yes ____ No ____ I wish to receive a copy of Notice of Privacy Practices.

Signed _____ Date _____

Name: Telephone :

If not signed by the patient indicate relationship

- Parent or guardian if patient is a minor
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient (if different than above) _____

For office use only:
Signed and received by: _____

Acknowledgment refused: _____

Efforts to obtain

_____

_____

Reasons for refusal

_____

_____